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State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

DATE: October 26, 2020

ALL PLAN LETTER 20-018
SUPERSEDES ALL PLAN LETTER 16-013

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: ENSURING ACCESS TO TRANSGENDER SERVICES

PURPOSE:

The purpose of this All Plan Letter (APL) is to remind Medi-Cal managed care health plans (MCPs) of their obligations to provide transgender services to members. This APL is a clarification of current policy and does not represent a policy change. This APL supersedes APL 16-013.¹

BACKGROUND:

Nondiscrimination Laws

The Insurance Gender Nondiscrimination Act (IGNA) prohibits MCPs from discriminating against individuals based on gender, including gender identity or gender expression.² The IGNA requires that MCPs provide transgender members with the same level of health care benefits available to non-transgender members.

The Affordable Care Act (ACA) and the implementing regulations prohibit discrimination against transgender individuals eligible for services and require MCPs to treat members in a manner consistent with the member's gender identity. The ACA requires that MCPs provide all members with a common core set of benefits, known as Essential Health Benefits (EHB). Health insurers covering EHBs are prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.³ Specifically, federal regulations prohibit MCPs from denying or limiting

¹ APLs and Policy Letters (PL), available to view at:

<https://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx>.

² The IGNA, which is codified in Health and Safety Code (HSC) section 1365.5, available to view at:

https://leginfo.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=1365.5.

³ For the purposes of this APL, the following nondiscrimination laws apply:

Title 42 United States Code (USC) section 18116, available to view at:

<https://uscode.house.gov/view.xhtml?req=18116&f=treesort&fq=true&num=1&hl=true&edition=prelim&granuleId=USC-prelim-title42-section18116>.

coverage of any health care services that are ordinarily or exclusively available to members of one gender to a transgender member based on the fact that a member's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available.⁴

Federal regulations further prohibit MCPs from categorically excluding or limiting coverage for health care services related to gender transition.⁵ Federal regulations similarly prohibit categorically restricting the scope of services to a member "solely because of the diagnosis, type of illness, or condition."⁶

MCP Contractual Obligations

MCPs are contractually obligated to provide medically necessary covered services to all members, including transgender members. State law defines "medically necessary" as follows:

(a) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.⁷

(b) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions.⁸

MCPs must also provide reconstructive surgery to all members, including transgender members. The analysis of whether or not a surgery is considered reconstructive surgery is separate and distinct from a medical necessity determination. State law defines reconstructive surgery as "surgery performed to correct or repair abnormal structures of

Title 45 Code of Federal Regulations (CFR) sections 92.206 and 92.207, available to view at:

<https://www.ecfr.gov/cgi-bin/text-idx?SID=ff51b982b46de527955dbb6d9e49b9d7&mc=true&node=pt45.1.92&rgn=div5>.

Title 45 CFR 156.125(b), available to view at: https://www.ecfr.gov/cgi-bin/text-idx?SID=52464edb2634121e38bf35a7adfb6770&mc=true&node=se45.2.156_1125&rgn=div8.

⁴ Title 45 CFR 92.206, 92.207(b)(3)

⁵ Title 45 CFR 92.207(b)(4)

⁶ Title 42 CFR 440.230(c), available to view at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1ee05b12856fc22e185b70107c113a9f&mc=true&node=pt42.4.440&rgn=div5>.

⁷ Welfare and Institutions Code section 14059.5, available to view at:

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC§ionNum=14059.5.

⁸ Title 42 USC 1396d(r)(5), available to view at:

<https://uscode.house.gov/view.xhtml?req=1396d&f=treesort&fq=true&num=60&hl=true&edition=prelim&granuleId=USC-prelim-title42-section1396d>.

the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease...to create a normal appearance to the extent possible.”⁹ In the case of transgender members, gender dysphoria is treated as a “developmental abnormality”¹⁰ for purposes of the reconstructive statute and “normal” appearance is to be determined by referencing the gender with which the member identifies.¹¹

MCPs are not contractually obligated to provide cosmetic surgery. State law defines cosmetic surgery as “surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.”¹²

POLICY:

Analyzing Transgender Service Requests

MCPs must analyze transgender service requests under both the applicable medical necessity standard for services to treat gender dysphoria and under the statutory criteria for reconstructive surgery. A finding of either “medically necessary to treat gender dysphoria” or “meets the statutory criteria of reconstructive surgery” serves as a separate basis for approving the request.

If the MCP determines that the service is medically necessary to treat the member’s gender dysphoria, the MCP must approve the requested service. If the MCP determines the service is not medically necessary to treat gender dysphoria (or if there is insufficient information to establish medical necessity), the MCP must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration the gender with which the member identifies.

The request for transgender services should be supported by evidence of either medical necessity or evidence supporting the criteria for reconstructive surgery. Supporting documentation should be submitted, as appropriate, by the member’s primary care provider, licensed mental health professional, and/or surgeon. These providers should be qualified and have experience in transgender health care.

When analyzing transgender service requests, MCPs must consider the knowledge and expertise of providers qualified to treat gender dysphoria (including the member’s

⁹ HSC 1367.63, available to view at:

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=1367.63.

¹⁰ The Diagnostic and Statistical Manual of Mental Disorder (DSM-5) characterizes gender dysphoria as “a marked incongruence between their [the member’s] experienced or expressed gender and the one they were assigned at birth.”

¹¹ HSC section 1367.63(c)(1)(B)

¹² HSC section 1367.63(d)

providers) and must use nationally recognized medical/clinical guidelines. One source of clinical guidance for the treatment of gender dysphoria is found in the most current “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People,” published by the World Professional Association for Transgender Health.¹³ Clinical guidance and literature regarding appropriate health care for transgender individuals is rapidly developing in light of new research and clinical experience. MCPs must continuously monitor current guidance on transgender health care to ensure consistency with current medical practice.

Nationally recognized medical experts in the field of transgender health care have identified the following core services in treating gender dysphoria: mental health services; psychotherapy; hormone therapy; and a variety of surgical procedures and treatments that bring primary and secondary gender characteristics into conformity with the individual’s identified gender.¹⁴ Surgical procedures and treatments that bring secondary gender characteristics into conformity with an individual’s identified gender may include, but are not limited to, sex reassignment surgery, facial gender confirmation surgery, body contouring, hair removal, and voice therapy and vocal surgery, if these services are determined to be medically necessary to treat a member’s gender dysphoria, or if the services meet the statutory definition of reconstructive surgery.

Utilization Controls

MCPs may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determinations, and/or apply appropriate utilization management criteria that are non-discriminatory. MCPs may not categorically exclude health care services related to gender transition on the basis that it excludes these services for all members.

MCPs must not categorically limit a service or the frequency of services available to a transgender member. For example, classifying certain services, such as facial feminization surgery, as always “cosmetic” or “not medically necessary for any Medi-Cal member” is an impermissible “categorical exclusion” of the service. MCPs must consider each requested service on a case-by-case basis and determine whether the requested service is either “medically necessary to treat the member’s gender dysphoria” or meets the statutory definition of “reconstructive surgery.”

Review of an MCP’s Denial of Services

If an MCP denies a request for transgender services on the basis that the services are not medically necessary, not considered reconstructive surgery, or do not meet the

¹³ See “Gender Dysphoria” in the DSM-5.

¹⁴ See Kellen Baker and Andrew Cray, “Ensuring Benefits Parity and Gender Identity Nondiscrimination in Essential Health Benefits,” Center for American Progression (Nov. 15, 2012).

MCP's utilization management criteria, the MCP's decision is subject to review through the MCP's appeal process, the State Fair Hearing process, and/or the Department of Managed Health Care's Independent Medical Review process, consistent with state and federal law.

MCPs are reminded that, when denying a requested service, the MCP must issue a notice of action (NOA) explaining "the reasons for the adverse benefit determination."¹⁵ The NOA must clearly state the reasons for the denial. The NOA must provide a detailed explanation of the specific reasons for the denial, a description of the criteria or guidelines used, and the clinical reasons for decisions regarding medical necessity to support the denial both on the basis of "not medically necessary to treat gender dysphoria" and "does not satisfy the criteria of the reconstructive surgery statute."

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures (P&P), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCP) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCP contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs. These requirements must be communicated by each MCP to all subcontractors and network providers.

¹⁵ Title 42 CFR section 438.404, available to view at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=1ee05b12856fc22e185b70107c113a9f&mc=true&node=pt42.4.438&rgn=div5>.

Also see APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, including any revisions or subsequent updates to this APL.

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If you have any questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division